State of Utah
DIVISION OF OCCUPATIONAL & PROFESSIONAL LICENSING

160 East 300 South, P.O. Box 146741
Salt Lake City, Utah 84114-6741
Telephone (801) 530-6628
www.dopl.utah.gov

License(s) Applying For:

- ☐ **PHYSICIAN TYPE ONE EDUCATOR** (***$200.00*** *Non Refundable Application Fee)*
- ☐ **PHYSICIAN TYPE TWO EDUCATOR** (***$200.00*** *Non Refundable Application Fee)*
- ☐ **CONTROLLED SUBSTANCE** (***$100.00*** *Non Refundable Application Fee)*

(Note: Microsoft Word users can fill in the blanks, print the form and save it for their records)

Please list your full legal name as it appears on your driver's license, Social Security Card, etc.		
Last Name:	First Name:	Middle Name:
Social Security Number: - -	Maiden Name:	

I certify under penalty of perjury that:

I certify under penalty of perjury that:

☐ I am a citizen of the United States and I have a valid US Driver License or US State ID.
License/State ID Number: _____ State: __

☐ I am a citizen of the United States currently living outside the United States and do not have a valid US Drivers License or US State ID. Please attach a legible copy of your valid passport or other documentation to verify you are a legal citizen of the United States.

☐ I am a non-citizen of the United States, who is lawfully present in the United States and I have a valid US Drivers License or US State ID.
License/State ID Number: _____ State: __

☐ I am a non-citizen of the United States, who is lawfully present in the United States and I do not have a valid US Drivers License or US State ID. Please attach a legible copy of your current and valid government issued document showing evidence of authorization to work in the United States.

☐ I am a foreign national not physically present in the United States.

Mailing Address:			
City:		State:	ZIP:
☐ Male ☐ Female	Date of Birth:	Phone #:	E-Mail:

List all other licenses, registrations, or certifications issued by any State /Country which you now hold or have ever held in any profession.
(Use additional sheets if necessary.)

Profession:	Issuing State/Country:	
License Number:	License Status:	Issue Date:
Profession:	Issuing State/Country:	
License Number:	License Status:	Issue Date:
Profession:	Issuing State/Country:	
License Number:	License Status:	Issue Date:
Profession:	Issuing State/Country:	
License Number:	License Status:	Issue Date:

DO NOT WRITE IN THIS SECTION - FOR DIVISION USE ONLY

License/Certificate Number: _____

Date License/Certificate Approved/Denied: ___/___/____ by _____

Reason for Denial/Other Comments: _____

_____

_____

Bureau Manager Review: QQ Yes answers or Education or Exam ❑ Approve ❑ Deny

AFFIDAVIT and RELEASE AUTHORIZATION FOR APPLICANT

1. I certify that am qualified in all respects for the license for which I am applying in this application.
2. I certify that to the best of my knowledge, the information contained in the application and its supporting document(s) is free of fraud, forgery, misrepresentation, omission of material fact; is truthful, correct, and complete; discloses all material facts regarding the applicant; and that I will update or correct the application as necessary, prior to any action on my application.
3. I authorize all persons, institutions, organization, schools, governmental agencies, employers, references, or any others not specifically included in the preceding characterization, which are set forth directly or by reference in this application, to release to the Division of Occupational and Professional Licensing, State of Utah, any files, records, or information of any type reasonably required for the Division of Occupational and Professional Licensing to properly evaluate my qualifications for licensure/certification/registration by the State of Utah.
4. I understand that it is the continuing responsibility of applicants and licensees to read, understand, and apply the requirements contained in all statutes and rules pertaining to the occupation or profession for which you are applying, and that failure to do so may result in civil, administrative, or criminal sanctions.
5. I understand that as holder of a Utah Controlled Substance licensee that I must comply with Utah Code Annotated §58-37f-401(3). This statute requires me to register with the Controlled Substance Database in order to hold a Utah Controlled Substance License.

Name: _____ Position:_____ Signature: _____ Date: _____

UTAH CONTROLLED SUBSTANCES LAW AND RULES EXAMINATION

This examination is not intended to be difficult. The purpose of the exam is to bring to your attention specific practice issues you need to know in order to avoid violating Utah statute as well as Utah law and rule. If you are uncertain about any of the questions listed below, please refer to the references listed in order to become familiar with Utah's controlled substance prescribing practices.

Utah Controlled Substances Act, 58-37 http://dopl.utah.gov/laws/58-37.pdf
Utah Controlled Substances Act Rule, R156-37 http://dopl.utah.gov/laws/R156-37.pdf

Answer "**True**" or "**False**" for each statement. Submit this completed examination with your application for licensure.

☐ True ☐ False	1. A prescription for a schedule II controlled substance may be filled in a quantity not to exceed a 30 day supply.
☐ True ☐ False	2. A prescription for a schedule III or IV controlled substance may be refilled 5 times within a six month period from the issue date of the prescription.
☐ True ☐ False	3. All prescription orders must be signed in ink or indelible pencil to prevent anyone from altering a legitimate prescription.
☐ True ☐ False	4. Licensed prescribing practitioners must make their controlled substance stock and records available to DOPL personnel for inspection during regular business hours.
☐ True ☐ False	5. All records of purchasing, prescribing, and administering controlled substances must be maintained by the licensed prescribing practitioner for at least five years.
☐ True ☐ False	6. The name, address, and DEA registration number of the prescribing practitioner, and the name, address and age of the patient are required to be included on the prescription for a controlled substance.
☐ True ☐ False	7. A controlled substance is taken according to the prescriber's instructions. A refill may be dispensed after 80% of the medication has been consumed.
☐ True ☐ False	8. After the discovery of any theft or loss of a controlled substance, the prescribing practitioner is required to file the appropriate forms with the DEA, report the incidence to the local police, and send copies of the filed DEA forms to DOPL.
☐ True ☐ False	9. The maximum number of controlled substances that can be written on a single prescription form is one.
☐ True ☐ False	10. An emergency verbal prescription order for a schedule II controlled substance requires that the patient be under the continuing care of the prescribing practitioner for a chronic disease, the amount of drug prescribed is limited to what is needed to adequately treat the patient for no more than 72 hours, and a written prescription shall be delivered to the filling pharmacy within 7 working days of the verbal order.
☐ True ☐ False	11. Issuing a prescription for a schedule II or III controlled substance for yourself is considered unprofessional conduct and may result in disciplinary action.
☐ True ☐ False	12. A prescribing practitioner is using a schedule IV controlled substance in the treatment of weight reduction for obesity. The practitioner has completed a medical history of the patient, has performed a complete physical examination, has ruled out contra-indications, and has determined that the health benefits of treatment greatly out-weigh the risks. An informed consent signed by the patient is also required prior to initiating treatment.
☐ True ☐ False	13. The Division will immediately suspend the Utah controlled substance license if the DEA registration is denied, revoked, surrendered, or suspended.

QUALIFYING QUESTIONNAIRE

Read thoroughly, and answer the questions. Do not leave any question blank.

(*Note: If you have formally expunged a criminal record you do not need to disclose that criminal history.*)

☐ Yes ☐ No	1. Have you ever applied for or received a license, certificate, permit, or registration to practice in a regulated profession under any name other than the name listed on this application?
☐ Yes ☐ No	2. Have you ever been denied the right to sit for a licensure examination?
☐ Yes ☐ No	3. Have you ever had a license, certificate, permit, or registration to practice a regulated profession denied, conditioned, curtailed, limited, restricted, suspended, revoked, reprimanded, or disciplined in any way?
☐ Yes ☐ No	4. Have you ever been permitted to resign or surrender your license, certificate, permit, or registration to practice in a regulated profession while under investigation or while action was pending against you by any health care profession licensing agency, hospital or other health care facility, or criminal or administrative jurisdiction?
☐ Yes ☐ No	5. Are you currently under investigation or is any disciplinary action pending against you now by any licensing agency?
☐ Yes ☐ No	6. Have you ever had hospital or other health care facility privileges denied, conditioned, curtailed, limited, restricted, suspended, or revoked in any way?
☐ Yes ☐ No	7. Have you ever been permitted to resign or surrender hospital or other health care facility privileges, while under investigation or while action was pending against you by any licensing agency, hospital or other health care facility, or criminal or administrative jurisdiction?
☐ Yes ☐ No	8. Is any action related to your conduct or patient care pending against you now at any hospital or health care facility?
☐ Yes ☐ No	9. Have you ever had rights to participate in Medicaid, Medicare, or any other state or federal health care payment reimbursement program denied, conditioned, curtailed, limited, restricted, suspended, or revoked in any way?
☐ Yes ☐ No	10. Have you ever been permitted to resign from Medicaid, Medicare, or any other state or federal health care payment reimbursement program while under investigation or while action was pending against you by any licensing agency, hospital, or other health care facility, or criminal or administrative jurisdiction?
☐ Yes ☐ No	11. Is any action pending against you now by Medicaid, Medicare, or any other state or federal health care payment reimbursement program?
☐ Yes ☐ No	12. Have you ever had a federal, state or country registration to sell, possess, prescribe, dispense, or administer controlled substances denied, conditioned, curtailed, limited, restricted, suspended or revoked in any way by either the federal Drug Enforcement Administration or any state/country drug enforcement agency?
☐ Yes ☐ No	13. Have you ever been permitted to surrender your registration to sell, possess, prescribe, dispense, or administer controlled substances while under investigation or while action was pending against you by any health care profession licensing agency, hospital or other health care facility, or criminal or administrative jurisdiction?
☐ Yes ☐ No	14. Is any action pending against you now by either the Federal Drug Enforcement Administration or any state/country drug enforcement agency?
☐ Yes ☐ No	15. Have you been named as a defendant in a malpractice suit?
☐ Yes ☐ No	16. Have you ever had office monitoring, practice curtailments, individual surcharge assessments based upon specific claims history, or other limitations, restrictions or conditions imposed by any malpractice carrier?
☐ Yes ☐ No	17. Have you ever had any malpractice insurance coverage denied, conditioned, curtailed, limited, suspended, or revoked in any way?
☐ Yes ☐ No	18. If you are licensed in the occupation/profession for which you are applying, would you pose a direct threat to yourself, to your patients or clients, or to the public health, safety, or welfare because of any circumstance or condition?
☐ Yes ☐ No	19. Have you ever been declared by any court of competent jurisdiction incompetent by reason of mental defect or disease and not restored?
☐ Yes ☐ No	20. Have you been terminated, suspended, reprimanded, sanctioned, or asked to leave voluntarily from a position because of drug use or abuse within the past five (5) years?
☐ Yes ☐ No	21. Have you ever had a documented case in which you were involved as the abuser in any incident of verbal, physical, mental, or sexual abuse?
☐ Yes ☐ No	22. Are you currently using or have you recently (*within 90 days*) used any drugs (*including recreational drugs*) without a valid prescription, the possession or distribution of which is unlawful under the Utah Controlled Substances Act or other applicable state, country or federal law?
☐ Yes ☐ No	23. Do you currently have any criminal action pending?
☐ Yes ☐ No	24. Have you pled guilty to, no contest to, entered into a plea in abeyance or been convicted of a misdemeanor in any jurisdiction within the past ten (10) years? Motor vehicle offenses such as driving while impaired or intoxicated must be disclosed but minor traffic offenses such as parking or speeding violations need not be listed.
☐ Yes ☐ No	25. Have you ever pled guilty to, no contest to, or been convicted of a felony in any jurisdiction?
☐ Yes ☐ No	26. Have you, in the past ten (10) years, been allowed to plea guilty or no contest to any criminal charge that was later dismissed (*i.e. plea-in-abeyance or deferred sentence*)?

☐ Yes ☐ No	27. Have you ever been incarcerated for any reason in any federal, state/country or county correctional facility or in any correctional facility in any other jurisdiction or on probation/parole in any jurisdiction?
☐ Yes ☐ No	28. Has any owner, officer, manager, pharmacist, pharmacy technician or medical practitioner associated with or employed by the applicant ever had a license, certificate, permit, registration to practice a regulated profession denied, conditioned, curtailed, limited, restricted, suspended, revoked, reprimanded, or disciplined in any way?
	**If you answered "yes" to any of the above questions, enclose with this application complete information with respect to all circumstances and the final result, if such has been reached. If you answered "yes" to Questions 23, 24, 25, 26, 27, 28 or 29 you must submit a complete narrative of the circumstances that occurred for EACH and EVERY conviction, plea in abeyance, and/or deferred sentence. You must also attach copies of all applicable police report(s), court record(s), and probation/parole officer report(s).** **If you are unable to obtain any of the records required above, you must submit documentation on official letterhead from the police department and/or court indicating that the information is no longer available.** **If you have formally expunged a criminal record as evidenced by a court order signed by a judge, you do not need to disclose that criminal history. Expungement orders must be sent to the Bureau of Criminal Identification and the FBI to enable the expungement to be completed and the criminal history eliminated from the records.** **A "Yes" answer does not necessarily mean you will not be granted a license; however, DOPL may request additional documentation if the information submitted is insufficient.**

DESIGNATION OF CONTACT PERSON FOR ACCESS TO MEDICAL RECORDS

In accordance with Subsection 58-67-302(1)(j) of the Utah Code and the Federal HIPAA Regulations every physician licensed in Utah must designate a contact person and an alternate contact person for access to his/her patients' medical records and provide such information to the DOPL. Each applicant is also required to establish a method of notifying patients of the identity and location of the contact persons (*i.e. a phone number or address where patients can obtain their medical records*).

If a hospital clinic or other medical facility is the owner of your patients' medical records the facility's records department could be listed as the primary contact. You may list yourself as the primary contact but you must also provide an alternate contact.

Please note that this statute became law in 2005 due to complaints from patients who could not gain access to their medical records. DOPL's responsibility is to collect each physician's contact information and to provide it to patients upon request. If you have not provided accurate information to DOPL you could be investigated for unprofessional conduct.

Contact Person:		Telephone:	
	Address of Contact Person:		
	City:	State:	Zip:
Alternate Contact Person:		Telephone:	
	Address of Contact Person:		
	City:	State:	Zip:

Method of Notifying Patients of Location of Records: (*check all that apply*)

☐ Phone
☐ Mail
☐ In Person

MEDICAL SCHOOL (*Use additional sheets if necessary.*)			
School Name:		Dates Attended:	to
	Location:		
	Degree Received:	Date of Graduation:	
School Name:		Dates Attended:	to
	Location:		
	Degree Received:	Date of Graduation:	

GRADUATE MEDICAL EDUCATION OR TRAINING – Complete the information below and account for **all** periods of training or postgraduate work from the time you graduated from medical school. (*Use additional sheets if necessary.*)			
Name of Hospital:		Position (*intern, resident, fellow*):	
	Address of Hospital:		
	City:	Issuing State/Country:	Zip:
	Department:	Date Began:	Date Ended:
Name of Hospital:		Position (*intern, resident, fellow*):	
	Address of Hospital:		
	City:	Issuing State/Country:	Zip:
	Department:	Date Began:	Date Ended:

PROFESSIONAL EXAMINATION REQUIREMENT		
# Attempts	Examination	Date(s) Taken
	USMLE Step 1	
	USMLE Step 2	
	USMLE Step 3	

# Attempts	Examination	Date(s) Taken

SPECIALTY BOARD CERTIFICATION - List your specialty board certification(s) and date(s) of specialty certification(s): (*Use additional sheets if necessary.*)	
Board:	Date:
Board:	Date:
Board:	Date:
Board:	Date:

Letters of Invite from an LCME accredited Medical school in Utah to be received from are: (*Use additional sheets if necessary.*)		
The Dean of the LCME accredited Medical school in Utah:		
	Date Requested:	
	☐ Yes ☐ No	Will the letter of invite state that the applicant has been appointed to a full-time faculty position, that because the applicant has unique expertise in a specific field of medicine the medical school considers the applicant to be a valuable member of the faculty, and that the applicant is qualified by knowledge, skill, and ability to practice medicine in the State of Utah?
The Head of the Department:		
	Date Requested:	
	Department Specialty:	
	☐ Yes ☐ No	Will the letter of invite state that the applicant will be under the direction of the head of the department and will be permitted to practice medicine only as a necessary part of the applicant's duties?
	☐ Yes ☐ No	Will the letter of invite provide detailed evidence of the applicant's qualifications and competence, including the nature and location of the applicant's proposed responsibilities, reasons for any limitations of the applicant's practice responsibilities, and the degree of supervision, if any, under which the applicant will function?

Federation Credentials Verification Service (FCVS):
Date "Other Special License" Packet Requested:

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PHYSICIAN TYPE ONE EDUCATOR DOCUMENTATION COVERSHEET

Attached And Submit This Cover Sheet With The Following:
(Applications with incomplete attachments will not be considered and may be denied.)

☐	Attach to this coversheet a current Curriculum Vita.
☐	Attach to this coversheet an original result of clinical research, within 10 years before the day on which this application is submitted, in a medical journal listed in the Index Medicus or an equivalent scholarly publication, with a verifiable, certified English translation, if needed.
☐	Attach to this coversheet proof of having held an appointment at a medical school approved by the LCME or at any medical school listed in the World Health Organization directory at the level of associate or full professor, or its equivalent, for at least five years.
☐	Attach to this coversheet documentation showing that the applicant has developed a treatment modality, surgical technique, or other verified original contribution to the field of medicine within 10 years and has the treatment modality, surgical technique, or other verified original contribution attested to by the dean of an LCME accredited school of medicine in Utah.
☐	Attach to this coversheet documentation showing that the applicant has actively practiced medicine cumulatively for 10 years; or is board certified in good standing of a board of the American Board of Medical Specialties or equivalent specialty board.
☐	Attach to this coversheet documentation proof of having practiced medicine for at least 10 years as an attending physician.

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PHYSICIAN TYPE TWO EDUCATOR DOCUMENTATION COVERSHEET

Attached And Submit With This Cover Sheet The Following:

(Applications with incomplete attachments will not be considered and may be denied.)

☐	Attach to this coversheet a current Curriculum Vita.
☐	Attach to this coversheet documentation that the applicant has delivered clinical care to patients cumulatively for five years after graduation from medical school.
☐	Attach to this coversheet documentation showing that the applicant will be completing a clinical fellowship while employed at the medical school described in the application or that the applicant has already completed a medical residency accredited by the Royal College of Physicians and Surgeons of Canada, the United Kingdom, Australia, or New Zealand, or a comparable accreditation organization.

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REQUEST FOR VERIFICATION OF LICENSE

(Use this form to verify licensure from another State/Country if applicable.)

TO BE COMPLETED BY THE APPLICANT:

Complete the first section of the form and submit it to a State/Country in which you are **currently** licensed. Request that the verifying State/Country complete the form and mail it directly to DOPL or return it to you for submission with your application.

Last Name:	First Name:	Middle Name:	
Maiden Name:	Social Security Number: - -		
Mailing Address:	City:	State:	ZIP:
Date of Birth:	E-Mail:	Date of Graduation:	
I am requesting licensure in the **STATE of UTAH** as a/an **PHYSICIAN EDUCATOR**			
I am/have been licensed in your State/Country under the name:		License # in your State/Country is/was:	
I have enclosed the necessary license verification fee in the amount of $			
Signature of Applicant:		Date:	

TO BE COMPLETED BY THE VERIFYING AGENCY:

Please furnish the information requested sign and verify the document and mail it directly to DOPL or place the completed form in a sealed envelope and provide it to the applicant in person or by mail. The applicant will include the sealed verification of licensure with his/her Utah application. Thank you.

Name of Verifying State/Country: _____

Name of Licensee (*as it appears in verifying State/Country's records*): _____

Classification of License Issued: _____

License Number: _____ Current Status: _____

Original Date of Licensure: ____/____/____ Expiration Date: ____/____/____

Continuously Licensed:

❑ Yes ❑ No please explain: _____

Licensed By:

❑ Exam Type: _____ Date: ___/___/_____

❑ Endorsement: from what State/Country?_____

Examination Scores: _____

Education Required for Licensure: _____

Disciplinary Action or Pending Disciplinary Action:

❑ No ❑ Yes please provide certified copies of all Petitions Orders etc.

Signature: _____

Title: _____

(SEAL)

Agency: _____

Date: ___/___/_____

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UTAH PHYSICIAN EDUCATOR

	Application Checklist *(Applications with incomplete attachments will not be considered and may be denied.)*
❑	Submit a complete DOPL application form to the DOPL address below.
❑	Attach a current Curriculum Vitae.
❑	Physician Type One Educator Coversheet with all required documents. or Physician Type Two Educator Coversheet with all required documents.
❑	Request an application packet from: **Federation Credentials Verification Service (FCVS)** Federation of State Medical Boards 400 Fuller Wiser Road, Suite 300 Euless, TX 76039 1-888-ASK-FCVS (888) 275-3287) fcvs@fsmb.org http://www.fsmb.org/fcvs.html . Complete their **"Other Special License"** application, submit it to FCVS and request that they submit the report directly to DOPL. ***Please note due to extended processing time of 60 to 90 days at FCVS you should request your FCVS packet 45 days prior to submitting your application to DOPL.***
❑	If **currently** licensed in another State/Country, submit verification of licensure from the State/Country that you are currently licensed in.
❑	**Submit Appropriate Application Fees** • Physician Type One Educator *($200.00 Non Refundable Application Fee)* • Physician Type Two Educator *($200.00 Non Refundable Application Fee)* • Controlled Substance *($100.00 Non Refundable Application Fee)*

You must hold a Utah controlled substance license and a Drug Enforcement Administration (DEA) registration to administer possess or prescribe a controlled substance in your practice of medicine in Utah. ***Contact the DEA at Salt Lake District Office 348 East South Temple Salt Lake City UT 84088. Telephone (801) 524-4389.***

1. **Social Security Number:** Your social security number is classified as a private record under the Utah Government Records Access and Management Act. If an SSN is not provided, the application is incomplete and may be denied.
2. **Address of Record:** The address you provide on this application will be your address of record. You are responsible to directly notify DOPL of any change to your address of record.
3. **Laws and Rules:** You are required to understand Utah laws and rules pertaining to your practice. The following laws and rules are available on the Internet at www.dopl.utah.gov.
4. **Controlled Substance License:** You must hold a Utah controlled substance license **AND** a federal DEA registration to administer, possess or prescribe a controlled substance in your practice in Utah.
5. **Acceptable Forms of Payment:** Licensure fees can be paid by check or money order, made payable to "DOPL." Cash and debit/credit cards (*American Express, MasterCard, and Visa*) are also accepted in person at DOPL's main office – but not over the telephone.
6. **Mail Complete Application** to:

   By U.S. Mail

   Division of Occupational & Professional Licensing
   P.O. Box 146741
   Salt Lake City, Utah 84114-6741

   By Delivery or Express Mail

   Division of Occupational & Professional Licensing
   160 East 300 South, 1st Floor Lobby
   Salt Lake City, Utah 84111
7. **Telephone Numbers:**

   (801) 530-6628
   (866) 275-3675 – Toll-free in Utah